BILL ANALYSIS

Senate Research Center

H.B. 3721
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Health & Human Services
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

H.B. 3721 creates an independent external medical review for denials of service, to determine medical necessity, just as is already done for commercial insurance. Currently, when a medical service is denied by a managed care organization (MCO), the patient must appeal within the insurance company. If that is unsuccessful, the next step is to appeal to the Health and Human Services Commission (HHSC) to determine not whether the service is medically necessary, but whether or not the policy followed by the MCO resulting in the denial is proper. There is thus no independent party considering whether the service is medically necessary.

H.B. 3721 provides that independent review in the same manner as is done for those with commercial insurance. Under the bill, a patient will have the right to have an independent clinical expert in the relevant area of medicine as the disputed service determine whether that service is medically necessary following the internal appeal by the MCO. If successful, the patient will then be entitled to that service. If not, the patient can proceed to the fair hearing process before HHSC that is already in place.

H.B. 3721 amends current law relating to an independent review organization to conduct reviews of certain medical necessity determinations under the Medicaid managed care program.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 1 (Section 533.039, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.039, as follows:

Sec. 533.039. INDEPENDENT REVIEW ORGANIZATIONS. (a) Defines "independent review organization."

(b) Requires the Health and Human Services Commission (HHSC) to contract with an independent review organization to make review determinations with respect to disputes at issue in requests for appeal submitted to HHSC challenging a medical necessity determination of a managed care organization that contracts with HHSC under this chapter (Medicaid Managed Care Program), except as provided by Subsection (b-1) or (g). Requires the executive commissioner by rule to determine:

(1) the manner in which an independent review organization is to settle the disputes;

(2) when, subject to Subsection (b-1), in the appeals process, an organization may be accessed; and

(3) the recourse available after the organization makes a review determination.

(b-1) Requires HHSC, with regard to a recipient dispute related to a reduction in or denial of services on the basis of medical necessity, to ensure that an independent review conducted by an independent review organization under this section occurs after the managed care organization has conducted an internal appeal and before the Medicaid fair hearing is granted. Authorizes a recipient, or the recipient's parent or legally authorized representative, described by this subsection to opt out of being subject to an independent review determination under this section and instead opt to proceed directly to a Medicaid fair hearing.

(c) Requires HHSC to ensure that a contract entered into under Subsection (b):

(1) requires an independent review organization to make a review determination in a timely manner as determined by HHSC;

(2) provides procedures to protect the confidentiality of medical records transmitted to the organization for use in conducting an independent review;

(3) sets minimum qualifications for and requires the independence of each physician or other health care provider making a review determination on behalf of the organization;

(4) subject to Subsection (c-1), specifies the procedures to be used by the organization in making review determinations;

(5) requires the timely notice to a recipient of the results of an independent review, including the clinical basis for the review determination;

(6) requires that the organization report the following aggregate information to HHSC in the form and manner and at the times prescribed by HHSC:

(A) the number of requests for independent reviews received by the independent review organization;

(B) the number of independent reviews conducted;

(C) the number of review determinations made:

(i) in favor of a managed care organization; and

(ii) in favor of a recipient;

(D) the number of review determinations that resulted in a managed care organization deciding to cover the service at issue;

(E) a summary of the disputes at issue in independent reviews;

(F) a summary of the services that were the subject of independent reviews; and

(G) the average time the organization took to complete an independent review and make a review determination; and

(7) requires that, in addition to the aggregate information required by Subdivision (6), the organization include in the report the information required by that subdivision categorized by managed care organization.

(c-1) Requires HHSC to establish a common procedure for independent reviews

conducted under this section. Requires the procedure to provide that a service ordered by a health care provider is presumed medically necessary and the managed care organization bears the burden of proof to show the service is not medically necessary. Requires medical necessity to be based on publicly available, up-to-date, evidence-based, and peer-reviewed clinical criteria. Requires HHSC to also establish a procedure for expedited reviews that allows the reviewer to identify an appeal that requires an expedited resolution.

(d) Requires an independent review organization with which HHSC contracts under this section to:

(1) obtain all information relating to the dispute at issue from the managed care organization and the provider in accordance with time frames prescribed by HHSC;

(2) assign a physician or other health care provider with appropriate expertise as a reviewer to make a review determination;

(3) for each review, perform a check to ensure that the organization and the physician or other health care provider assigned to make a review determination do not have a conflict of interest, as defined in the contract entered into between HHSC and the organization;

(4) communicate procedural rules, approved by HHSC, and other information regarding the appeals process to all parties; and

(5) render a timely review determination, as determined by HHSC.

(e) Requires HHSC to ensure that the managed care organization, the provider, and the recipient involved in a dispute do not have a choice in the reviewer who is assigned to perform the review.

(e-1) Provides that an independent review organization's review determination of medical necessity establishes the minimum level of services a recipient is required to receive.

(f) Prohibits a managed care organization described by Subsection (b) from having a financial relationship with or ownership interest in an independent review organization with which HHSC contracts. Requires HHSC, in selecting an independent review organization with which to contract, to avoid conflicts of interest by considering and monitoring existing relationships between independent review organizations and managed care organizations. Requires an independent review organization with which HHSC contracts to:

(1) be overseen by a medical director who is a physician licensed in this state; and

(2) employ or be able to consult with staff with experience in providing private duty nursing services and long-term services and supports.

(g) Provides that this section does not apply to, and an independent review organization is prohibited from making a review determination with respect to, a dispute involving HHSC's office of inspector general or an action taken at the direction of that office, including a dispute relating to:

(1) an action taken by a managed care organization at the direction of the office under the lock-in program established in accordance with 42 C.F.R. Part 431.54(e); or

(2) the termination or potential termination of a provider's enrollment in a

managed care organization's provider network at the direction of the office.

(h) Requires the executive commissioner of HHSC to adopt rules necessary to implement this section.

SECTION 2. Requires a state agency affected by any provision of this Act, if before implementing the provision the state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, to request the waiver or authorization and authorizes the agency to delay implementing that provision until the waiver or authorization is granted.

SECTION 3. Effective date: September 1, 2019.